Ambivalence in transference and countertransference

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AMBIVALENCE IN TRANSFERENCE AND COUNTER-TRANSFERENCE. FEELINGS OF RAPPROCHEMENT AND REJECTION IN (FORENSIC) PSYCHOANALYTIC PRACTICE AND DISCLOSURE AS AN ANALYTIC WEAPON.*

As is our custom in our Netherlands...his reputation was quickly pruned back to reasonable proportions. (W. Otterspeer, Orde en trouw (2006), p. 12.)

T.I. Oei

Introduction and definition

Whether (forensically) traumatized or not, when treating mentally disturbed patients in which very early pre-Oedipal problems are not present, it is commonplace nowadays that numerous ambivalences manifest themselves. These are so numerous that one might even compare their number to the grains of sand on a beach. Permit me to begin with a few examples.

Arriving late to or missing an appointment altogether is one of many ambivalent situations. One of my analytic patients took more than five years before he stopped coming late or would contact me if he could not come; for many years he could not even discuss these issues. Arriving late was his way of testing me as a therapist and, moreover, was a demonstration that he did not need me. This was largely not his conscious experience or his well prepared way of doing things. On the contrary, it was something he did unconsciously, as if he were not in control of himself. Not showing up for an appointment was also an expression of a certain freedom, as when children say 'no' to their mothers while simultaneously enjoying being fed by them. Ambivalences are often stubborn and can be a life-long source of annoyance for the patient, not to mention their partner and friends. Arriving late is not a meaningless symptom, but rather a quite meaningful one.

Another analytic patient always arrived exactly on time and if he could not come would phone either just before or just as his appointment began to say that he had been delayed and would not be able to come. One might imagine that this kind of behavior was related to an anal problem, but often things were somewhat more complicated than that. An anal problem is clearly recognizable by virtue of its badly structured (sometimes chaotic) form, rigid character

and predictable recurrence. This making a mess of things usually constitutes an easily recognizable pattern. Yet this patient's primary problem was his ambivalence toward me as a therapist. He was very reserved in expressing emotion and feared becoming attached to me.

This fear of attachment was accordingly the source of his exact and almost compulsive handling of time. He could neither spend time on his own activities, nor was he prepared to consider that time spent could also be time saved. He had an ambivalent relation to time. His greatest fear was ultimately that of dying, the final moment of permanent parting. Paul van Tongeren explains this beautifully: "Activities that appear to take, rob us of time; those that appear to give, bestow time. Only he who knows how to give time has time to give."[1] Another example deals with the simultaneous nourishment of feelings of attraction and rejection for a person one likes.

A patient began her story by stating that she had come to therapy reluctantly, had worked out for herself those things she should relate, and had wondered what I as an analyst would find good. During her bike ride to my office she also enjoyed the daybreak, contemplated the rising sun, and felt its warmth on her back. The latter reminded her of the sensation of sinking into a warm bath and the back massages her mother gave her when as a child she had taken a bath every Saturday. When asked why she thought of this she replied that her father never did this for her and when she thought of me she excluded any possibility of my doing so, although she had longed for just this several times during the last week.[2]

Which ambivalences?

In contrast to the primitive splitting mechanism in which the other is perceived as "all good" or "all bad",[3] the experience of simultaneously having opposite feelings for a person or thing (i.e., ambivalence) is always evident in every psychoanalytic session. I should immediately add that I wish here to use the phenomenon of ambivalence as merely a superficial expression of or vehicle for the emotional contact between patient and therapist in transference and counter-transference. Thus I shall not further analyze unconscious mechanisms in the sense of

[1] Van Tongeren, 2006.
[2] Angela Joyce, *A young baby and his Mum: Winnicott's good enough mothering revisited*. International Conference 'Donald Winnicott Today'. London, 11 June 2006.
[3] See Stroeken, 1994, p. 18-19.

convergence (directed toward a single goal) or divergence (extraction)[4], although these naturally play a role, for that would demand more time and exceed the boundaries of this paper.

According to Bleuler,[5] ambivalence takes three forms: ambivalence of the will, *ambitendency* (the presence of opposing behavioral drives); intellectual ambivalence, seeking two opposing goals simultaneously; and affective ambivalence in which a single impulse can mean two different feelings (e.g., love and hate). At the risk of appearing vain, it is the final meaning of ambivalence which interests me here.

Ambivalences usually serve both real and symbolic functions. They represent feelings of rejection and simultaneously – or sometimes consequently – also feelings of rapprochement. In many situations this is actually expressed as feelings of love and hate. Sometimes this interaction between *taking the initiative* and *surrendering,* gaining power over someone or submitting to someone else's power, crosses the limits of human decency:

'My darling! I do not wish to see you today or tomorrow – not until the evening of the following day, and at that point I want to see you *as my slave*. Your Mistress, Wanda'[6]

Based on brief examples,[7] I shall here address the most common and probably the most important ambivalences in analytic treatment: the mutual denial of desires and longings by the patient and the other (the therapist) on one side and feelings of rejection, contempt, anger and hatred on the other. Also the nourishing of fantasies regarding the joint work, the amalgamation, becoming one with another (that is to say with the analyst) is a regressive phenomenon which must be worked through the transference and counter-transference.[8]

Using examples from the animal kingdom, I shall first explain that human behavior is sometimes, but not always, quite predictable, although difficult to attune to individual

[4] See A.O. Kris, 1985, p. 537-568.
[5] See also Laplanche & Pontalis, 1980, p. 26*ff*.
[6] Sacher-Masoch, 2006, p. 48. That a similar attitude would suggest perversion will be made clear. For further research into perverse behavior amongst criminal sex offenders see the dissertation by K.M. Lehnecke, 2004.
[7] This is a diagonal way of working, in contrast to a longitudinal approach in which individual treatment lasting years is followed and subsequently analyzed and studied based on specific criteria.
[8] Counter-transferential feelings are essential because they permit the analyst to join the patient in searching for his defensive feelings. For the analyst, the struggle lies in the counter-transference neurosis, that is making these feelings fully conscious.

situations. Unconscious factors play a role in this to some degree. Several unconscious mechanisms and phenomenon will be very briefly mentioned as will parallel processes in literature and music by way of illustration. Clinical examples serve to more exactly define the terms in question. When working with transference and counter-transference, it is important to have a certain feeling of safety during treatment. For this reason technical aspects, such as containment and interpretation are essential. Finally, the extreme feelings in transference and counter-transference of love and hate, rapprochement and rejection will be examined more closely and recommendations will be made for the treatment of these kind of ambivalences in psychoanalysis via the analytic weapon of disclosure.

One man's delight is another's boredom

This is probably the most characteristic aspect of the dynamics of rapprochement and rejection. What is an interesting, attractive, exciting (even orgasmic) advance for some, is for others none of these. Since man and animals share quite a bit in common, let us take as intermezzo a brief discussion of a natural phenomenon. The giant panda is known as a peculiar animal whose appearance makes the human heart beat faster. Yet nobody dares or longs to develop sexual feelings for it. Despite this, there are people to whom this indeed does happen. This animal is well known as a solitary being. The female of the species is only fertile for a few hours per year and even if a pair have only a few seconds of sexual contact that can be sufficient to achieve fertilization. Unfortunately this chance is very small and this is why giant panda couples fail to produce young. In these cases we should not speak of deviant panda behavior, for the animal is behaving in conformity with its hormonal and situational condition. The males often have no interest in sex at all, even when the female makes passionate attempts to entice him, for example by rubbing her rear against his genitals. Their desire to copulate is clearly not determined by hormones alone. What then is decisive? Is it a desire for sex, trusting someone and therefore also wanting to copulate, or is it merely coincidence that produces impregnation? This is no different with people, although their behavior is often less clear at first sight.

Patient X, who is twenty years my junior, went out with a colleague Y of his who was twenty years old. They drank heavily and decided that rather than going home by car they would stay overnight at the closest hotel they could find. Y reveals that he is not in a relationship,

but likes younger men. He most likes to spend time with people his own age, but avoids emotional contact with men. His friend, Z, told him that she thinks that he may well be bisexual or perhaps homosexual. He related that since he was eight years old he had been in love with boys and that when he sees good looking boys he often fantasizes them naked; conversely, when he sees naked women he regularly fantasizes that they were clothed. Z understands him well and keeps the secret. He has been living for the last few years together with a somewhat older man who is a theoretical philosopher. Y travels the world with him when on vacation. They sleep together in one bed, but do not have sex.

When asked, Y confesses that he wants to have sex with his housemate, but is afraid of rejection. Everything is great, Y says, but if he were to reject me then my world would collapse. Rather than share his feelings with his friend, he fantasizes instead.

One late evening he suddenly proposed to X that they jack off one another. X, who had never had a homosexual experience, thought it a good idea, but is afraid of the feelings this might generate. X said, "I could probably love you so much that I would leave my wife which I don't want to risk because I'm happy with her."

The transference is clearly recognizable. My patient X wanted to join with me, but was afraid of sexual feelings, a fear he subsequently projected on his younger colleague who reacted with unrestrained emotion. As therapist I felt the sexual tension that X directed toward me in his story. My interpretation was that he wanted to seduce me, but was afraid that either I would fall in love with him or would reject him. For this reason he did not seek to seduce me by letting me know his feelings directly, but did so by displacing them onto his relationship with his younger colleague.

X confirmed that he had indeed had sexual fantasies about me in which I was naked, but had never considered his desire as serious nor had he decided not to express it out of fear of rejection. As an analyst I experienced the ambivalences in the counter-transference which I had toward my own feelings and my availability as a therapist for this patient. I follow my patient well and experience erotic feelings for him, but do not want to mention them given that I had mixed feelings as a child for my father because he wasn't there sometimes and left me on my own. Can I shake my hesitancy over this issue and would that serve a therapeutic end? I decided not to do that and suspect that my patient sensed I was wrestling with these

feelings, for sometimes I was a bit short when he spoke about his feelings for men. When asked, the patient said he was familiar with this attraction and rejection with his mother when, during his latency,[9] she often rebuked him in comparison to his brother and father who she believed had done better than he in life. He endured such humiliations repeatedly whenever his mother felt rejected because he did not want her to fuss over him or, even worse, fiddle with his nipples, for example.

Unconscious "fantasizing", daydreaming, conscious fantasies, preconscious fantasies

The disparity powerful/powerless is a characteristic of every psychoanalytic treatment and is an extension of the rapprochement and rejection duality.

In "Joe Speedboat"[10] the principle player fantasizes about everything. He was virtually crippled in an accident and can only turn his head slightly and use one arm. He is visited by family and fellow villagers, but also fantasizes or dreams about his favorite love so that he might also father a child. After all, the others visit him even if they always go away again. They do not stay with him and he often feels lonely. The author's style is smooth and the book reads quickly, but the feeling one gets when reading it is often missing a certain excitement, as if there were no plot. Also, what attention is given to interpretation? The reader must repeatedly reach his own conclusion, or doesn't he? In this example, we cannot determine whether we are dealing with an unconscious fantasy, a daydream or preconscious phenomenon. These are wish-fulfilling dreams which simultaneously indicate his enormous sorrow to such a degree that he is hardly able to seduce a woman, let alone have sex with her. This world of loneliness and the agitation of his unrelenting fears forced upon him the idea that his fears simply *could* not last forever.

The main character says: "The fact is that I'm stopped dead in my tracks in a dark house that pressures on my back. My view is of the window sill's dead flies, spider webs and dust balls. My fears are all active; they don't drive me crazy, they're awake. And there they are together lunging for the throat, no longer pretty. Beasts! Child molesters! Things! In short: panic. Yet

[9] The latency phase occurs during mental development (between the age of six and puberty) and is characterized by sexual development entering calmer waters, replaced in part by feelings of shame and disgust.

how long can one continuously be frightened without anything actually happening? It slowly becomes a difficult feeling and if nothing happens one laughs at oneself."

Patient C was having problems at school. He had grown up in a very religious environment in which he took everything said literally. The other students called him 'Professor' and he avoided every confrontation out of fear of being teased. He became convinced like a missionary, that all his opinions would not reach the 'weak-minded.' This permitted him to think increasingly less about what had happened to him and his feelings about it. Feelings were for him foreign and sometimes taboo because they disorient. He viewed fantasies as difficult and not morally trustworthy. This individual was a very nuanced speaker who could change his mind three times during the course of a single meeting if new information so warranted. He never took sides in order to appear non-controversial. When in a relationship in which he felt safe and could speak about this in the analysis, his fears were clearly lessened. His fear of being in a relationship[11] and of the secure knowledge that nothing else could change as he learned about himself was an extreme reaction to his traumatic youth during which religious belief, providing security and distrust of other ways of thinking were omnipresent. The desire to fantasize also languished for this reason and it took years before he dared to give his unconscious a chance and permitted himself to speak about his dreams.

According to Freud, fantasies consist of a psychic reality which is different from material reality. We slowly understand that in the neurotic's world certain factors form psychic reality.[12] The German word *Phantasie* expresses both dream ideas and day dreams. Day dreams are the harbinger of hysterical symptoms. These are not related to actual memories, but to fantasies based on memories.[13]

'Unconscious fantasy is with the notion of 'Nachträglichkeit' (deferred action) the fiction which has been cathected with affect.'

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[11] The unsafe attachment is nicely prominent here in the form of avoidance: the desire to no longer feel anything. This is more than just ambivalence, but is preoccupied attachment in which ambivalences are still felt.
[12] Freud, 1916-1917, 16, p. 368.
[13] 'The hysteric may present a theme to the analyst – sexual fear, despair, suicide – but it is not meant to be examined; it is intended to capture the analyst through the power of the image.' See Bollas, 2000, p. 95. It is important to note that the term 'unconscious' is also ambiguous. According to Freud's topographic schema, there is a difference between the 'pre-conscious' and the 'unconscious'. The pre-conscious functions as storage for thoughts, desires and ideas which can become conscious relatively easily, while the unconscious functions as storage for infantile, libidinous wishes and desires which were repressed earlier in childhood and are only accessible via primary process functions, such as laughing, crying, etc. R. Steiner (ed.), *Unconscious Phantasy*. London: Karnac, 2003.

The unconscious fantasy transforms into second nature in those who suffered sexual trauma as a child and are saddled with the parent's feelings of guilt. Feelings of guilt are then an expression of the feeling of having fallen too short vis-à-vis the parent, yet these feelings can also be actualized preceding the progress/development of every form of sexual rapprochement. Coupled with a sexual trauma, the rejection as expressed in the mother's humiliation of my patient X was thus sexualized and henceforth contributed to the ambivalences which now manifest themselves in every form of human contact. Patient X felt it intuitively when he had trouble with his parents, with women, or with people for whom he worked. He had developed an unconscious proclivity for *and* an acknowledged fear of the desire to sexualize attraction and rejection. Each time he met someone who reminded him of the powerful/powerless situation from his youth with his mother, he wanted to seduce and overpower them via the sexual act. This was expressed in a submissive posture as slave or seducer. A somewhat authoritative woman is then seen as if she were not wearing clothing and a strict teacher is the focus of an oral sex fantasy. The nature of these fantasies certainly has a conscious – sometimes a preconscious – aspect, because the patient could often not remember well what precisely gave rise to the fantasy. Was it the woman as woman, the woman who in some other way reminded him of his mother, or the woman who was simply irritating? Or was it pure fear of not being able to tolerate being powerless or the overwhelming situation of once again having a woman in control of his fears, as his mother had once been. The grade of consciousness of this fantasy provided more clarity and thus more aspects of consciousness, as the more was known about those who it concerned and more fear it inspired in X. The powerlessness which patient X feared was covered over by the fantasy of his being forced to provide oral sex. He had the other in his power in as much as he was the one providing pleasure and could consequently bend him to his will.[14]

'Containment' and interpretation (rather: first 'containment', then interpretation)

In the series of ambivalences between surrender and keeping one's distance, feelings of dependence and independence play a meaningful role. One of my patients repeatedly

[14] As Fairbairn (1954) reports: 'The first defence used by "the original ego" is the alliance with "an unsatisfying personal relationship", which constitutes an introjection of the "unsatisfying object" (p. 15). This unsatisfactory state consists of an object that "has two disturbing aspects, viz. an exciting aspect and a rejecting aspect" (p. 16) The hysteric's object is both excessively exciting and excessively rejecting.' See Fairbairn, 1994, p. 13-40.

returned to his fear of attachment. He was very tactful with his girlfriend, a trait which expressed itself in sexual foreplay: she would reach orgasm when he stroked her throat. Yet he was afraid of excessive dependence and how she might lay claims on him. As an analyst I had had years of difficulty with the fact that he was not open to considering this idea, even when I provided clues. Thus for the time being it was more a question of clarification or elucidation of his feelings and of what we recognized in what grew between us emotionally and relationally. In short, we worked on *containment* until he began once again with his "on one hand…on the other hand." He was happily reunited with his girlfriend, but was simultaneously afraid of making too many dates with her and the oppressive feeling he got when he thought about how she might lay claims on him. I indicated that I had noticed that he had not given off any signals of the fear with which he had begun treatment, namely her faithlessness on account of the fantasy that he might leave her for another. He admitted that this was so and then fell silent. "You touched a sensitive nerve," he said. I asked him what that feeling had to do with and he answered: "My mother also demanded complete transparency from me and I always wanted to struggle against that. It's as if I've become allergic to it." I answered by saying: "You also find it very oppressive when I ask you about your contact with your girlfriend because then I'm just like your mother who also required something like this of you." He was quiet, but then suddenly became emotional. He closed his eyes and tears rolled down his face. "It is also so difficult that no matter who asked I viewed every question about that subject as an attack on my privacy," he revealed, softly sobbing. In "Constructions in Analysis," Freud reminds us that psychoanalytic treatment is always about two people, analysand and analyst: the latter's task is to discern the forgotten traces left behind or better said, to hypothesize it. Freud further remarks that the timing and way in which the analyst deals with these constructions and reaches out to the person being analyzed as well as the explanation he offers must form the link between the two parts of analytic work, namely the analyst and the patient. Similar constructions form the relationship between *fabula* and *sjužet*: the working out of a coherent and explanatory relationship between 'events' (real as well as imagined) and their narratological meaning. The relationship between patient and analyst is comparable to the reconstruction of past images, that is, the story's link with the plot by whomever is telling it.[15]

[15] See Freud, *Standard Edition*, p. 257-269 and also Brooks, 2002, p. 320*ff* and idem, p. xi. Plot is the design and the meaning of that which is told. This forms a story and provides a certain direction or sense or meaning.

Love and hate in transference and counter-transference

Patient A had been coming to me for months, but he often arrived very late or missed appointments (without advance notice), and when he did arrive he would apologize verbosely. This eventually led to a moment of confrontation. He interrogated me because he thought he did not hear or see enough of me and that, according to him, I was not tangible for him. He had had a very ambivalent relationship with his father who had often belittled him and compared him negatively to his younger brother who was evidently cleverer, more technically inclined and more energetic. The patient's father did not think he should become a mechanic or engineer, but 'would be permitted' to study education, a discipline my patient thought was considered softer. He felt humiliated by this and therefore had a love-hate relationship with his father. This patient also had an ambivalent relationship with me. On one hand he distrusted me because as a non-*blanda (i.e. a non-native Dutchman).* I had the same background as his father (who was a native Indonesian) and he felt that I equally remained aloof from contact with him. He believed we were dealing with non-contact. I could not deny that there had been times I had thought myself incapable of helping this patient and even moments of relief when he did not make appointments. The feelings of humiliation and neglect which he had experienced with his father as a child were projected onto me and I sometimes felt ill, just as he had experienced. When I was able to express my feelings of being humiliated and neglected ("you must have been *very* deeply hurt") and clearly confronted him with the fact that he was capable of humiliating me just as well with his aloof behavior, just as he had experienced with his father ("the feeling of being put down keeps you so busy and you think of what your father represented at that time that you would come to no good and that you never had any plans"), he was better able to control his late arrivals. I concluded that my feelings of hate for his behavior, and also for him, had prevented me from saying anything about this until that moment. In retrospect, this appeared to be a milestone in the analytic process given that it meant for him that in one respect he could not figure me out and for this reason had to stay alert. Yet on the other hand he was able to count on my tolerance which effected a certain feeling of intimacy: I had not rejected him, no matter *what* he did to or with me. Very probably determined by my counter-transferential neurosis, my reaction pattern to the patient's projections (I am perfectly capable of making my desires known and generally inveigh strongly) put me in a position to prevent my reacting as a

projected part of the patient's internal world. Instead of reacting in a way Grinberg[16] described as a form of projective counter-identification (this is as a required internal object toward the passive rebelliousness even of the patient), I was able to give space to the developing corrective experience. In Epstein's words[17] I appeared to be in a position to deal with the patient which made it difficult to correct or even consolidate the secondary breaks in development to which the patient had become used.

The unconscious: language and affect

Language is not the unconscious, for what originates in the unconscious does not form language. While the unconscious does not form a homogeneous state, language does.[18] In fact, the unconscious is full of affect. This is also the current thinking on affect and is increasingly expressed in facts and stories about treatment which deal with affect, emotion and language as acknowledgement of that which can provide access to the unconscious. A famous song by David Bowie serves to illustrate this:

We passed upon the stairs,
We spoke of was and when
Although I wasn't there
He said I was his friend
Which came as a surprise
I spoke into his eyes -- I thought you died alone
A long long time ago

Oh no, not me,
We never lost control,
You're face to face,
With the man who sold the world

[16] Grinberg, 1979, p. 375-405.
[17] Epstein, 1977, 13, p. 442-468.
[18] This does not detract from Jacques Lacan in whose argument that the unconscious is structured like a language Freud was central. Compare remarks made by Lacan's students that he is difficult to read and his style is sometimes labelled 'impossible', not to mention the fact (one which Lacan himself was well aware) that the unconscious is particularly difficult to fathom. See J. Feher-Gurewich (ed.) & J. Dor, 1998. See also A.W.M. Mooij, *Taal en verlangen*, Amsterdam: Boom, 6e druk, 2002.

I laughed and shook his hand,
I made my way back home,
I searched for form and land,
Years and years I roamed,
I gazed a gazely stare,
We walked a million hills -- I must have died alone,
A long long time ago.

Who knows, not me,
I never lost control,
You're face, to face,
With the man who sold the world.

This song has since been memorably interpreted by Nirvana in the person of the late Kurt Cobain.[19] It was literally an ode by the (often under the influence) Kurt Cobain to the unattainable relationship which was characterized by complete surrender to the other. Cobain had always been a somewhat mythic figure, having grown up in a broken home and survived both the adventures and fickleness of street life. He was the very prototype of the seriously neglected child who longed for love and surrender. Such a child daydreams, uses drugs, makes music and often employs symbols for unresolved and frequently bygone expectations. Music is a unique partner in the language used for these purposes. When successful, music and language are like hand and glove. They do not get in each other's way, but are mutually reinforcing and synergetic. Yet the question remains whether the unconscious can be discovered in music. There are musicians and composers who firmly believe in the creative possibilities of music and lyrics and that these can elevate the listener to a higher plane of abstraction or ecstasy. The stormy affect in Brahms' *Ein Deutsches Requiem* reaches a climax in the second passage. It is as if the listener were in a coffin and listening together with the dead with candid passion to all the beauty which awaits in heaven.

I once gave an interview to a professional magazine about psychotherapy. The magazine was for a general audience and designed to be accessible to all. Patient B came across the piece and his comments boiled down to the following:

[19] He was named godfather of Grunge (a kind of rock music), a 'rock visionary' and 'the voice of the disaffected.' *Guitar World*, May 2006, p. 7.

> I initially felt an inclination to analyze the piece's content and style. This usually meant that I didn't know how to cope with my emotions. I then noticed that I was touched by this important moment. You exposed a bit of yourself. I thought that was cool. I was surprised at your material needs (shopping, cars) although upon reflection I think I could have guessed these things, but I realized that I wanted to see you as an ascetic Buddhist. Now I note that you're a person (as when I complimented you on your nice shirt and you became diffident, a moment I found immensely sweet). I also experienced your other sides, the educator/instructor/father/etc. in this way.
>
> I now think of you as being less distant. I put you less frequently up on a pedestal. You've become more human to me, someone I like tremendously. It's also exciting to get to know you a little as a person. I've noticed that at one stroke this has released a great many thoughts.
>
> The writer also made me realize that she is a bit in love with you.
>
> Warmly,

Patient B had indeed expressed this to me earlier, but I found I needed to place it within a professional setting. Yet it is also true that fantasies about the therapist can be related to a patient's particular preferences or dislikes. Patient B had recently been studying Eastern sports and philosophy and had already apportioned me a place in his world of Buddha and such. He did not find me his type, but did like that I was prepared to listen to his desires when he was willing to give voice to them. To that extent he experienced me in a way that he could not at home: giving oneself over to a partner who is always there or at least always could be there. This was the source of his infatuation with me and this must be said: I also dreamt about him. My counter-transferential feelings sprang from devoting myself to a patient whom I really wanted to help. This took place within a quasi-omnipotent availability.[20]

Discussion

Freud included the term transference neurosis (*Übertragungsneurose*) as part of a group of neuroses (hysteria and compulsive neurosis) which he differentiated from the actual and narcissistic neuroses. What is essential about these neurotics is that their perception has been

[20] 'To get validation' is the analysand's desire (as child) toward the parent (the analyst). Gabbard, 2004, p. 129. It is interesting to see that parenthood includes not only behaving responsibly with one's child (basic provisions such as food and care), but also paying attention and being affectionate. Adoption provides legal parenthood which then severs the legal bonds with the birth parents. See Amsterdam Court Decision from 23 December 2004, numbers 745/04 and 1129/04 LJN-nr. AR7915. Is not the attention and affection the analyst gives his patient – being there, positive, patient, tolerant and accepting – also a form of 'parenting'?

strongly distorted by childhood experiences with important people in their lives. The conflicts they were unable to resolve at that time continue to determine their lives; their earlier experiences are carried over into the present. The transference neurosis is central to psychoanalytic technique and originates in the relationship with the analyst. It is a transference during the treatment that has become structural. It is a repetition of problems experienced with parents. Interpretation of the transference neurosis exposes infantile neurosis.

As regards the counter-transference neurosis, the repetition of early childhood conflicts with the analyst during psychoanalytic treatment (in the form of enactments, actualizations, and projective identification)[21] can create identical problems in the form of interpretation by the patient for the analyst and the analytic process. The balance of both actors' investment in the analytic process is decisive for its success. A chess-like situation can arise in which the analyst cannot determine what to do unless he remains alert and open for signals from the patient to learn how to create an open-ended situation. Professor Piet Kuiper asserted that "the patient is always right" and it is indeed the case that one sees this regularly. Patients with good will can only profit from analytic progress. They are in this sense just as responsible as the analyst for the form and content of therapeutic work. Patients regularly like to hear that the analyst is capable of dealing with what is going on in the analysis. Sometimes this involves aspects of the patient's resistances, but only sometimes.

This paper has focused on the duality between rapprochement and rejection as modalities of feeling and as experiences in psychoanalytic treatment,[22] a treatment that is very intensive and lasts many years. This process involves not only factors having to do with the patient, but also therapist variables.[23] The patient's infantile neurotic problems displays aspects which can be re-experienced during the analysis, but of course – whether we like it or not – this is also

[21] See also Renik, 1993, p. 553-571. In the event this should become a personal problem for the analyst then in addition to internal reflection and self-analysis, re-analysis is also possible and sometimes even recommended. *Actualizations* are treatments which are often manifest themselves counter-transferentially by the analyst instead of or earlier than speaking about the issue in analytic treatment or supervision. When dealing with projective identification, the term *enactment* is the manifestation of a counter-transferential reaction during the actualizing of transference fantasy. See Chused, 1991, p. 629.

[22] The what, how and why of any given psychoanalytic treatment cannot be explained well, let alone effectively. How, for example, can one describe the feeling of uprootedness if one knows nothing of it personally? 'There really is no way to know what psychoanalysis is all about other than by way of personal experience.' See J. Reeder, 2004, p. 109. for a balanced discussion of modern psychoanalysis see F. Schalkwijk, *Dit is psychoanalyse*, Amsterdam: Uitgeverij Boom, 2006.

[23] Searles, 1986. Verder Carpy, 1989, p. 287-294.

true for the analyst. If things run their proper course, there comes a moment when the transference neurosis and the counter-transference neurosis sort of bloom, when neither rationally nor emotionally a confrontation between patient and analyst can no longer be avoided. A clash between these two actors over correct interpretation or explanation or a form of self-disclosure by the patient *and* the analyst can literally create a new situation from which both can profit. Finally, this is about getting the analytic process moving again and this is the crucial point at that moment. Between egos which would sooner or later have had such a confrontation, this kind of conflict can achieve wonders. Both the primary process (the coenesthetic) and the secondary process (the diacritic) must be given a chance to develop.[24] Cooperation between these two processes is sometimes like walking on eggs and waiting for just the right moment to arrive, the moment when the patient can bear the considerable emotional weight of confronting his analyst.[25] It is up to the analyst to determine when that moment has arrived. What is beyond dispute is that empathy and self-acceptance are inextricably linked to this process.

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[24] See Gorney, 1979, p. 288-337. See also Lampl-de Groot, 1985, p. 284-294, particularly p. 288. However subjective the analyst is in his interpretations of the analytic situation, these can still have objective value. See R. Peter Hobson et al., 1998, p. 172-177.
[25] See Winnicott, 1949, p. 69-74. Compare W. Otterspeer, 2006, p. 14.

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* This contribution is principally written for the non-specialized, yet academically trained and interested reader with an interest in the psychoanalytic world of interactional ambivalence and the treatment of seriously traumatized patients, whether forensic or otherwise. The form of presentation takes into account that too strict an argument would compromise the goal of sharing information and insight into therapeutic practice. My thanks to J.E.M. Bakker, F. Schalkwijk, P. van Woerden.

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